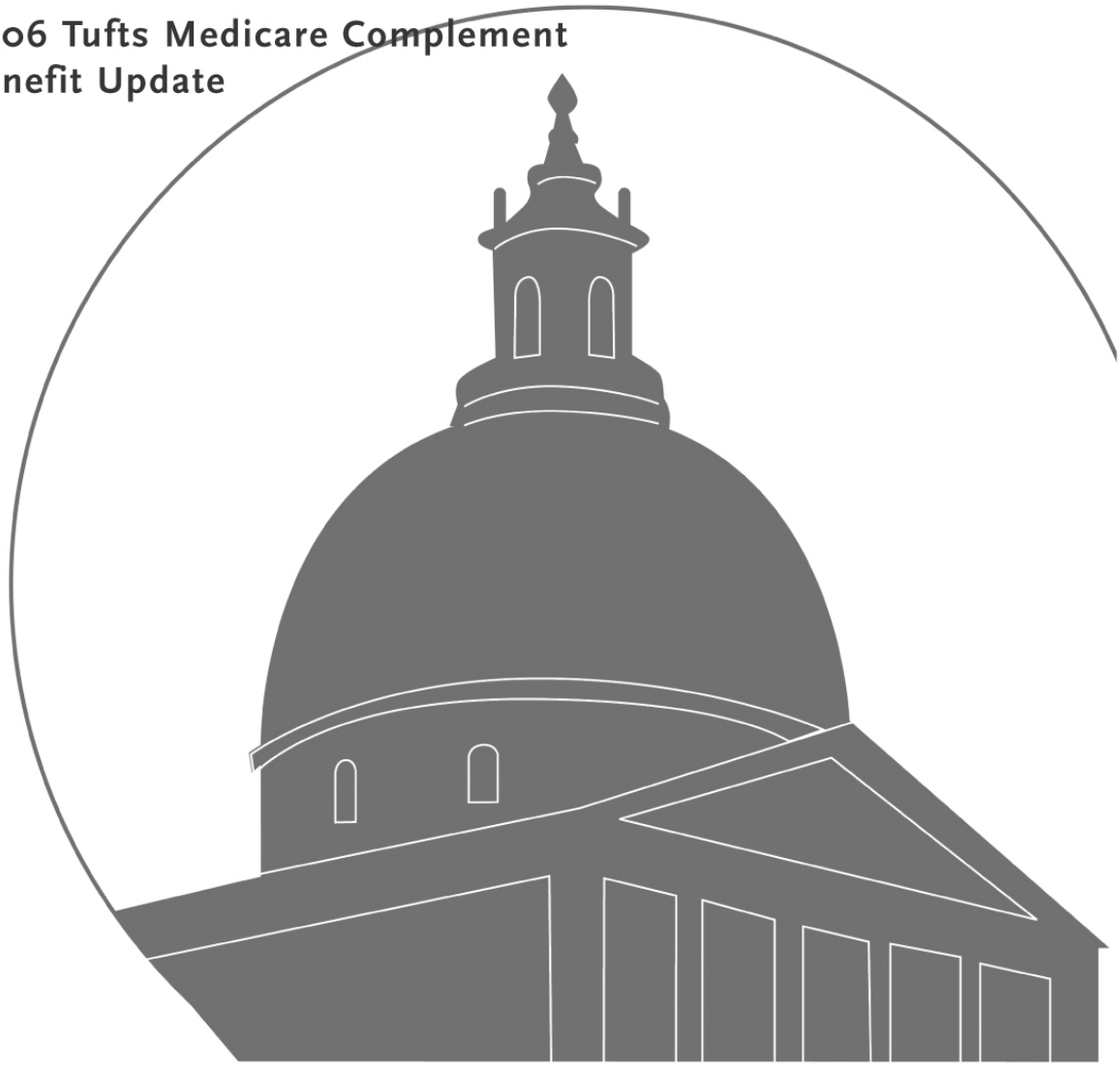
TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

> 2006 Tufts Medicare Complement Benefit Update



GIC TMC Benefit Update (2006)

The information below amends or clarifies the language in the following Tufts Medicare Complement ("TMC") documents for the Group Insurance Commission ("GIC"):

- GIC TMC Evidence of Coverage ("EOC") - 7-2003 edition; and
- GIC TMC Benefit Updates - 7-2004 and 7-2005 editions.

This 2006 GIC TMC Benefit Update includes *benefit clarifications* and other important information about your health care coverage under the Group Insurance Commission's Tufts Health Plan TMC option. You should put these pages in your TMC Evidence of Coverage for easy reference. If you have any questions, please call a Member Services Coordinator at **1-800-870-9488**.

2006 Updates:

This section describes benefit clarifications and benefit revisions to your health care coverage under the GIC's Tufts Health Plan TMC option. These changes and revisions are effective as of July 1, 2006, unless otherwise indicated below.

Benefit Revisions:

Chapter 3 – Covered Services

•Part A Benefits – Hospital Inpatient services provided at a Medicare-certified general hospital

The paragraph in this provision describing removal of breast implants, found on page 3-3 of the 2003 EOC, is changed to read as follows:

Removal of a breast implant is covered when any one of the following conditions exists:

(1) the implant was placed post-mastectomy;

(2) there is documented rupture of a silicone implant ; or

(3) there is documented evidence of auto-immune disease.

Important: No coverage is provided for the removal of intact or ruptured saline breast implants or intact silicone breast implants except as specified above.

•Part B Benefits –Outpatient services

The benefit description for covered diagnostic x-ray services, found on page 3-15 of the 2003 EOC, is changed to read as follows:

- Diagnostic imaging services, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, PET and nuclear medicine;

Chapter 3 – Exclusions from Benefits

The exclusion related to routine foot care found in the "Exclusion of Benefits" section on page 3-41 of the 2003 EOC is changed to read as follows:

- Routine foot care, such as: trimming of corns and calluses; treatment of flat feet or partial dislocations in the feet; orthopedic shoes and related items that are not part of a brace; foot orthotics or fittings; or casting and other services related to foot orthotics or other support devices for the feet. This exclusion does not apply to routine foot care for Members diagnosed with diabetes.

  Note: This exclusion does not apply to therapeutic/molded shoes and shoe inserts for a Member with severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the Member's treating doctor, and the shoes and inserts:

  - are prescribed by a Provider who is a podiatrist or other qualified doctor; and
  - are furnished by a Provider who is a podiatrist, orthotist, prosthetist, or pedorthist.

Appendix B – List of Non-Covered Drugs

Effective January 1, 2006, the list of "Non-Covered Drugs with Suggested Alternatives" found in Appendix B of your 2003 Evidence of Coverage (as amended on pages 10-11 of the 2004 Benefit Update and pages 1-2 of the 2005 Benefit Update) is changed to read as follows:

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2006 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see the Plan's Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator.

Brand Name	Suggested Alternatives
Abilify solution	Abilify tablets (Tier 2, middle Copayment)
AcipHex	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest Copayment), Nexium or Prevacid (Tier-3, highest Copayment)
Ambien CR	Ambien or Sonata (Tier-2, middle Copayment); Lunesta (Tier-3, highest Copayment)
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest Copayment)
Atacand HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest Copayment)
Avalide	Benicar HCT, Diovan HCT, or Hyzaar (Tier-3, highest Copayment)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest Copayment)
Axid	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest Copayment)
Beconase AQ	Nasacort AQ, Flonase, Nasonex, or Rhinocort Aqua (Tier-2, middle Copayment)
BiDil	Isosorbide dinitrate and hydralizine (Tier 1, lowest Copayment)
Bright Beginnings Prenatal Supplement Bars	prenatal vitamins plus iron (Tier-1, lowest Copayment)
Capoten	captopril (Tier-1, lowest Copayment)
Clarinex	loratidine (OTC, not covered); fexofenadine (Tier 1, lowest Copayment) or Zyrtec (Tier-3, highest Copayment)
Dynacin	minocycline hcl capsules (Tier-1, lowest Copayment)
EC Naprosyn	enteric-coated naproxen (Tier-1, lowest Copayment)
Evoclin	clindamycin phosphate 1% lotion (Tier-1, lowest Copayment)
Flagyl, Flagyl ER	metronidazole tabs (Tier-1, lowest Copayment)
Genotropin	Humatrope, Norditropin, Nutropin, Protropin, Saizen (Tier-2, middle Copayment)
Klonopin	clonazepam (Tier-1, lowest Copayment)
Lagesic	Aceta-Gesic (OTC, not covered)
Lidex, Lidex-E	fluocinonide and fluocinonide E (Tier-1, lowest Copayment)
Lopressor	metoprolol (Tier-1, lowest Copayment)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit (Tier-1, lowest Copayment)
Megace ES	megestrol acetate oral suspension (Tier-1, lowest Copayment)
Mevacor	lovastatin (Tier-1, lowest Copayment)
Micardis	Benicar, Cozaar, or Diovan (Tier-3, highest Copayment)
Micardis HCT	Benicar HCT, Diovan HCT and Hyzaar (Tier-3, highest Copayment)
Minocin	minocycline hcl capsules (Tier-1, lowest Copayment)
Monodox	doxycyline monohydrate (Tier-1, lowest Copayment)
Myrac	minocycline tablets (Tier-1, lowest Copayment)
Naprelan	naproxen sodium extended-release (Tier-1, lowest Copayment)
Niravam	alprazolam (Tier-1, lowest Copayment)
Pepcid (except suspension)	cimetidine, famotidine, nizatidine, or ranitidine (Tier-1, lowest Copayment)

(continued on next page)

Appendix B – Non-Covered Drugs With Suggested Alternatives - continued

Brand Name	Suggested Alternatives
Prevacid Naprapac	naproxen (Tier-1, lowest Copayment) plus Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest Copayment), Nexium or Prevacid (Tier-3, highest Copayment)
Prilosec	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest Copayment), Nexium and Prevacid (Tier-3, highest Copayment) PLEASE NOTE: Prilosec is covered for Members 12 years of age and younger (Tier-3, highest Copayment)
Prinivil	lisinopril (Tier-1, lowest Copayment)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest Copayment)
Reprexain	hydrocodone/ibuprofen (Tier-1, lowest Copayment)
Rozerem	Ambien or Sonata (Tier-2, middle Copayment); Lunesta (Tier-3, highest Copayment)
Sporanox capsules (itraconazole)	Lamisil tablets (prior authorization required) (Tier-3, highest Copayment)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest Copayment)
Teveten HCT	Benicar HCT, Diovan HCT or Hyzaar (Tier-3, highest Copayment)
Valium	diazepam (Tier-1, lowest Copayment)
Vasotec	enalapril (Tier-1, lowest Copayment)
Vicoprofen	hydrocodone/ibuprofen (Tier-1, lowest Copayment)
Xanax/Xanax XR	alprazolam (Tier-1, lowest Copayment)
Zegered	Prilosec OTC (OTC, not covered), omeprazole (Tier-1, lowest Copayment), Nexium or Prevacid (Tier-3, highest Copayment)

Changes to Other Provisions:

Chapter 1 – About Your Primary Care Physician:

•What a PCP does

This section, found on page 1-7 of the 2003 EOC, is revised to read as follows:

A PCP:

- provides routine health care (including routine physical examinations);
- arranges for your care with other Tufts HP Providers; and
- provides referrals for other health care services, except for mental health services. See "Inpatient and intermediate mental health/substance abuse services" later in this chapter for more information about obtaining referrals for these services.

Your PCP, or a Covering Physician, is available 24 hours a day.

Your PCP will coordinate your care by: treating you, or referring you to specialty services.

•Referrals for specialty services

Under the "Notes" section of this provision, found on page 1-9 of the 2003 EOC, the second bulleted item is changed to read as follows:

- For mental health and substance abuse services, you do not need a referral from your PCP; however, you may need authorization from a Tufts HP Mental Health Authorized Reviewer. See "Inpatient and intermediate mental health/substance abuse services" later in this chapter for more information.

•Authorized Reviewer approval

This section, found on page 1-9 of the 2003 EOC, is revised to read as follows:

If the specialist refers you to a non-Tufts HP Provider, the referral must be approved by your PCP and an Authorized Reviewer. In addition, certain Covered Services described in Chapter 3 must be authorized in advance by an Authorized Reviewer, or, for mental health or substance abuse services, from a Tufts HP Mental Health Authorized Reviewer. If you do not obtain that authorization, Tufts HP will not cover those services and supplies.

•Inpatient mental health/substance abuse services

The final paragraph of this section, found on page 1-15 of the 2003 EOC, is revised to read as follows:

If you live in an area where the Plan's Designated Facilities are not available, and you are therefore not assigned to a Designated Facility, you must call the Tufts HP Mental Health Department at 800-208-9565 for more information on where you may receive Inpatient mental health/substance abuse services at a Tufts HP facility.

•What to Do When Traveling

The description of coverage for Routine Care outside of the Service Area, found in the table in this section on page 1-17 of the 2003 EOC (as amended on page 11 of the 2005 Benefit Update), is revised to read as follows:

Type of Service	Example	Coverage
Routine Care	• routine general physical examinations; • routine gynecological or obstetrical examinations; • diagnostic tests related to general physical and gynecological examinations; • ongoing treatment for a psychiatric condition; • immunizations to prevent disease; and • other preventive procedures.	Not covered

Chapter 4 – When Coverage Ends:

•Voluntary and Involuntary Disenrollment Rates for Members

The "Voluntary and Involuntary Disenrollment Rates for Members" section on page 4-3 of the 2003 EOC (as amended on page 4 of the 2004 Benefit Update) is revised as follows:

As required by Massachusetts law, Tufts Health Plan conducts an annual disenrollment study. Annually, the study looks at the reasons Members leave Tufts Health Plan, in order to track voluntary and involuntary disenrollment rates.

Voluntary Disenrollment Rate - The number of Members Tufts Health Plan disenrolled because they ceased to pay Premiums. This is the voluntary disenrollment rate. For the year 2005, less than one percent of Members voluntarily disenrolled by ceasing to pay their Premiums.

Involuntary Disenrollment Rate - The number of Members that Tufts Health Plan disenrolled because of fraud or acts of physical or verbal abuse. This is the involuntary disenrollment rate. For the year 2005, less than one percent of Members were involuntarily disenrolled as a result of fraud or abuse.

For additional information about the voluntary and involuntary disenrollment rates among Tufts Health Plan Members, call Tufts HP.

Chapter 5 – Member Satisfaction:

•Member Satisfaction Process

The "Member Satisfaction Process" section, found in Chapter 5 of the 2003 EOC (as amended on pages 5-9 of the 2004 Benefit Update and pages 12-17 of the 2005 Benefit Update), is revised as follows:

Expedited Appeals

The first paragraph of the "Expedited Appeals" section, found on page 8 of the 2004 Benefit Update (as amended on page 15 of the 2005 Benefit Update), is revised to read as follows:

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the 30 calendar days allotted for the standard Appeals Process. Tufts HP will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending physician should contact the Member Services Department. Under these circumstances, you will be notified of Tufts HP's decision within seventy-two (72) hours after the review is initiated. If your treating physician (the physician responsible for the treatment or proposed treatment) certifies that the service being requested is Medically Necessary; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process, you will be notified of Tufts HP's decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for Durable Medical Equipment (DME) that Tufts HP determined was not Medically Necessary, you will be notified of Tufts HP's decision within less than forty-eight (48) hours of the receipt of certification. If you are an Inpatient in a hospital, Tufts HP will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at Tufts HP's expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by Tufts Health Plan and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

External Review by The Office of Patient Protection

The seventh paragraph of the "External Review by the Office of Patient Protection" section, found in Chapter 5 of the 2003 EOC (as amended on page 9 of the 2004 Benefit Update and pages 16-17 of the 2005 Benefit Update), is revised as follows:

The decision of the review panel will be binding on Tufts HP. If the external review agency overturns a Tufts HP decision in whole or in part, *Tufts HP* will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures for obtaining the requested coverage or services;
- advise you of the date by which the payment will be made or the authorization for services will be issued by *Tufts HP*; and
- include the name and phone number of the person at *Tufts HP* who will assist you with final resolution of the grievance.

•Bills from Providers

The fourth paragraph of the "Medical Expenses" section of the "Bills from Providers" provision, found on page 5-10 of the 2003 EOC (as amended on page 17 of the 2005 Benefit Update), is revised to read as follows:

> Please note: You must contact Tufts HP regarding your bill(s) or send your bill(s) to Tufts HP within six months from the date of service. If you do not, the bill cannot be considered for payment.

Chapter 6 – Other Plan Provisions:

•Subrogation

The "Subrogation" section found on pages 6-1 and 6-2 of the 2003 EOC (as amended on page 18 of the 2005 Benefit Update) is changed as follows:

- Under the "Tufts Health Plan's right of subrogation" provision, the references to "services" in the third paragraph have been changed to "services or medications."
- The provision entitled "The Plan's right of reimbursement" is changed to read as follows:

  Tufts Health Plan's right of reimbursement

  In addition to the rights described above, if you recover money by suit, settlement, or otherwise, you are required to reimburse Tufts HP for the cost of health care services, supplies, medications, and expenses for which Tufts HP paid or will pay. Tufts HP has the right to be reimbursed up to the amount of any payment received by you, regardless of whether (a) all or part of the payment to you was designated, allocated, or characterized as payment for medical expenses; or (b) the payment is for an amount less than that necessary to reimburse you fully for the illness or injury.

•The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The above referenced provision has been added to Chapter 7 of your 2004 TMC Evidence of Coverage and reads as follows:

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your Dependents while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.
- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at www.dol.gov/vets. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Commission.

GROUP HEALTH CONTINUATION COVERAGE UNDER COBRA

You are receiving this notice because you are covered under the *Group Insurance Commission's* (*GIC's*) health benefits program. This notice contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

WHAT IS COBRA COVERAGE? COBRA is a federal law under which certain former employees, retirees, *Spouses*, former *Spouses* and *Dependent Children* have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called 'Qualifying Events.' If you elect COBRA coverage, you are entitled to the same coverage being provided under the *GIC's* plan to similarly situated employees or *Dependents*. The *GIC* administers COBRA coverage.

This notice explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage, contact the *GIC's* Public Information Unit at 617/727-2301, ext. 801 or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's website at **www.dol.gov/ebsa**.

WHO IS ELIGIBLE FOR COBRA COVERAGE? Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an *independent right* to elect the coverage, regardless of whether or not other eligible family *members* elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

If you are an employee of the Commonwealth of Massachusetts covered by the *GIC's* Health benefits program, you have the right to choose COBRA coverage if

- You lose your group health coverage because your hours of employment are reduced; or
- Your employment ends for reasons other than gross misconduct.

If you are the *Spouse* of an employee covered by the *GIC's* health benefits program, you have the right to choose COBRA coverage for yourself if you lose *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- Your *Spouse* dies;
- Your *Spouse's* employment with the Commonwealth ends for any reason other than gross misconduct or his/her hours or employment are reduced; or
- You and your *Spouse* divorce, legally separate, or you or your former *Spouse* remarries.

If you have *Dependent Children* who are covered by the *GIC's* health benefits program, each *Child* has the right to elect COBRA coverage if he or she loses *GIC* health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies;
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours or employment are reduced;
- The parents divorce or legally separate; or
- The *Dependent* ceases to be a *Dependent Child* (e.g., is over age 19 and is not a full time student, or ceases to be a full-time student).

HOW LONG DOES COBRA COVERAGE LAST? By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended beyond the initial 18-month period up to a *total* of 36 months (as measured from the initial qualifying event) if a second qualifying event – the insured's death or divorce - occurs during the 18 months of COBRA coverage. **You must notify the *GIC* in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage**. Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the *GIC* with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18 month COBRA period ends in order to extend the coverage**.

COBRA coverage will end before the maximum coverage period ends if any of the following occurs:

- The COBRA cost is not paid ***in full*** when due (see section on paying for COBRA);
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits;
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability);
- The Commonwealth of Massachusetts no longer provides group health coverage to any of its employees; or
- Any reason for which the *GIC* terminates a non-COBRA enrollee's coverage (such as fraud).

The* GIC *will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The* GIC *reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.

HOW AND WHEN DO I ELECT COBRA COVERAGE? Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60–day election period, you will lose all rights to COBRA coverage**.

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a *Spouse's* plan) within 30 days after your COBRA coverage ends.

HOW MUCH DOES COBRA COVERAGE COST? Under COBRA, you must pay 102% of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150% of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

HOW AND WHEN DO I PAY FOR COBRA COVERAGE? If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the *GIC* receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period**. After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The *GIC* will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement**. Payments should be sent to the *GIC's* address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

CAN I ELECT OTHER HEALTH COVERAGE BESIDES COBRA? Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance 'conversion' policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

YOUR COBRA COVERAGE RESPONSIBILITIES

- **You must inform the *GIC* of any address changes to preserve your COBRA rights;**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above**. If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill**. If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.
- **You must inform the *GIC* within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**
  - The employee's job terminates or his/her hours are reduced;
  - The employee or former employee dies;
  - The employee divorces or legally separates;
  - The employee or employee's former Spouse remarries;
  - A covered Child ceases to be a Dependent;
  - The Social Security Administration determines that the employee or a covered family member is disabled; or
  - The Social Security Administration determines that the employee or a covered family member is no longer disabled.

If you do not inform the *GIC* of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the *GIC* of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

GIC TMC Benefit Update (2006)

Important Notice

About Your Prescription Drug Coverage and Medicare

The Centers for Medicare Services requires that this NOTICE OF CREDITABLE COVERAGE be sent to you. Please read it carefully and keep it where you can find it.

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and the new Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE NEW MEDICARE DRUG PLANS', SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.

The New Medicare Drug Plans

The new Medicare prescription drug benefit, also known as Medicare Part D, will be offered through various health plans and other organizations. All Medicare prescription drug plans will provide at least the standard level of coverage set by Medicare; some plans might also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a new Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.
- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan, Harvard Pilgrim Health Care First Seniority or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.

- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Creditable Coverage Information

Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage will pay. This means that your GIC coverage is "Creditable Coverage." You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. After May 15, 2006, if your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1% per month for every month after May 15, 2006 that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.medicare.gov .
- Call the Group Insurance Commission at 1-617-727-2310.

Notice of Group Insurance Commission Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as "protected health information" or "PHI") includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at www.mass.gov/gic.

Required and Permitted Uses and Disclosures
We use and disclose protected health information ("PHI") in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

Payment activities: The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

Health Care Operations: The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

Other Permitted Uses and Disclosures:
The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals);
- to verify agency and plan performance (such as audits);
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement);
- for judicial and administrative proceedings (such as in response to a court order);
- for research studies that meet all privacy requirements;
- to tell you about new or changed benefits and services or health care choices.

Required Disclosures: The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal Representative), when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

Organizations that Assist Us: In connection with payment and health care operations, we may share your PHI with our third party "Business Associates" that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

Your rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.
- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research;
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request. (an electronic version of this notice is on our website at www.mass.gov/gic.

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 801 or TTY for the deaf and hard of hearing at (617)-227-8583.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS Health Plan
No one does more to keep you healthy.

Tufts Health Plan
333 Wyman Street, P.O. Box 9112
Waltham, MA 02454-9112

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

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